FRAMEWORK FOR STATE EVALUATION OF CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

(Developed by States, for States to meet requirements under Section 2108(b) of the Social Security Act)

State/Territory: District of Columbia

The following State Evaluation is submitted in compliance with Title XXI of the Social Security Act (Section 2108(b)).

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(Signature of Agency Head)

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SECTION 1. SUMMARY OF KEY ACCOMPLISHMENTS OF YOUR CHIP PROGRAM

This section is designed to highlight the key accomplishments of your CHIP program to date toward increasing the number of children with creditable health coverage (Section 2108(b)(1)(A)). This section also identifies strategic objectives, performance goals, and performance measures for the CHIP program(s), as well as progress and barriers toward meeting those goals. More detailed analysis of program effectiveness in reducing the number of uninsured low-income children is given in sections that follow.

1.1 What is the estimated baseline number of uncovered low-income children? Is this estimated baseline the same number submitted to HCFA in the 1998 annual report? If not, what estimate did you submit, and why is it different?

1.1.1 What are the data source(s) and methodology used to make this estimate?

Summary of Data and Methods Used

The District of Columbia employed the services of The Lewin Group, Inc. in developing its numerical estimates for uninsured children. The primary data source was the District of Columbia Current Population Survey (CPS) for 1995 and 1996 conducted by the Bureau of the Census. Although there are more authoritative sources on the size of the District population of adults and children, the CPS is the only data source available that provides the income and insurance coverage data required to analyze programs to expand coverage. Consequently, the CPS data was adjusted to reflect other population control totals where available. The number of persons who would become eligible and enrolled in the program because of an eligibility expansion was estimated. This estimate was derived from the District of Columbia CPS data using the Lewin Group State Medicaid Eligibility Model (SMEM), which is specifically designed to model changes in eligibility under public programs.

Population Data

The Lewin analysis of the demographic characteristics of children in the District of Columbia and the number of children potentially affected by the children's health initiative are based upon the March Current Population Survey (CPS) data for 1995 and 1996 developed by the Bureau of the Census. These survey data are based upon a representative sample of the US population, which provides information on the demographic, economic and the insurance coverage characteristics of the population. The District of Columbia subsample of these data provides a representative sample of the District's population that can be used to estimate the number of children who would be potentially eligible for coverage under the children's health initiative. However, there is a concern over the sample size of the CPS at the state level. To account for this, District of Columbia subsamples of the CPS were pooled over the two most recent survey years (1995 and 1996), each of which provides an independent sample of households in the District. In the pooled sample, all households surveyed in the District of Columbia in 1995 are added to the District subsample for 1996 to create a single database for the District with twice the number of observations than if only the 1996 data were used. The sample weights for each District household in the database were reduced by half so that the pooled database reports the number of persons in the District. By pooling samples from 1995 and 1996, the reliability of the estimates are improved for narrowly defined classes of individual such as low-income children.

The Bureau of the Census attempts to construct the CPS survey that it includes all persons in the District, including the homeless and undocumented immigrants. The only groups omitted from the survey are institutionalized persons (i.e. nursing home residents, persons on prison, etc.). The survey also excludes persons living in group quarters (facilities with 10 or more residents). This means that students living in dormitories are not included on our sample. This is appropriated

because these persons are typically considered dependents of parents living in other states.

Adjustments to CPS Data

It was necessary to make certain adjustments to the District subsample of the CPS to correct for certain problems with these data. First, as Mr. George Grier of the Greir Partnership has shown, the numbers of children and adults reported in the CPS for the District are as much as 20 percent higher than what current research indicates as the true population in the District. In fact, the population counts in the CPS data are actually higher than the Bureau of the Census's official projections of the District's population. (Note: The Bureau of the Census is aware of this problem and recommends using their official District population projects for total population counts by age rather than the CPS data). Moreover, the CPS data show a steady increase in the population in the District since 1990 even though the official Bureau of the Census population projections show a decline in the District's population. (Note: The Bureau of the Census has not published an explanation for these discrepancies in their population projections). The estimates of the number of children in the District developed by the Grier Partnership also show a reduction in population in the District although they estimate even fewer children than in the Bureau of the Census population projection.

Based upon consultations with both Grier and the Bureau of the Census, the population counts for the District were adjusted to replicate the Bureau's population projections for the District. These estimates are somewhat higher than Grier's population estimates for children in the District. They also reflect the trend towards further declines in the District's population, which both the Bureau of the Census and Grier are projecting.

Second, the CPS data underreports the number of persons who are enrolled in the District's Medicaid program. This reflects the fact that when interviewed, some Medicaid recipients are either unable or unwilling to provide information on their participation in public programs. Consequently, CPS data were adjusted to reflect the actual level of Medicaid enrollment for children in the District of Columbia.

Third, we estimated number of undocumented immigrants in the CPS data for the District of Columbia so that we were able to reflect the impact of excluding undocumented immigrants from the CHIP program. Based upon data provided by various government agencies, we estimate that there were about 20,000 undocumented aliens living in the District in 1996. This is based upon the estimated number of expired visas for District residents provided by the US Immigration and Naturalization Service (INS) and Bureau of the Census studies on the number of undocumented persons living in each state and the District of Columbia. Based upon CPS data on the percentage of foreign-born persons living in the District who were under the age of 19, we estimated that about 4,407 of these 20,000 undocumented persons are children. About 20,000 persons in the CPS who reported that they were not US citizens, which includes both legal and illegal immigrants, were randomly assigned to undocumented immigrant status, and these individuals were considered ineligible for either Medicaid or the CHIP program.

Simulation of Eligibility

Estimates of the number of children who would become covered under the CHIP program were derived using the Lewin Group State Medicaid Eligibility Model (SMEM). This model uses the CPS data to: (1) identify persons who meet the age and residency requirements to be eligible for CHIP; and (2) determine children's eligibility based upon their family's reported incomes. The model also estimates the number of these eligible persons who would enroll in the program. The model also includes certain data enhancements designed to more accurately represent the eligibility determination process.

For example, income eligibility for Medicaid is based upon the monthly income of the applicant filing unit rather than annual income. This is important because a family with annual income in

excess of a given income eligibility limit, such as the poverty level, may have had several months during the year where their income was below the eligibility limit and other months when it was above the eligibility limit. We account for this by spreading income for filing unit members across the months during the year in which income is received (i.e. earning during periods of employment, etc.) And estimating the number of eligible persons during each month of the year to develop average monthly eligibility estimates. The steps involved in this estimation process include:

- **Number of Potentially Eligible Persons:** The model estimates the number of persons that would meet the income and categorical eligibility criteria specified under the expansion. This is done using the District subsample of the pooled CPS data, which includes the detailed income and family characteristics data required to develop these estimates. The model also estimates the number of persons who are already eligible for the program but are not enrolled so that these individuals are not counted as newly eligible.

- **Unique Program Definitions:** The model reflects unique aspects of the Medicaid eligibility determination process. For example, the model simulates the unique definition of a family unit used under the program. It also models the program's monthly income eligibility determination process under which individuals may be eligible for only certain months during the year.

- **Program Enrollment:** Not all persons who are eligible for Medicaid enroll. Nationwide, only about 76 percent of eligible persons enroll in the program. Enrollment rates decline even more as income rises. The model uses these data to estimate the portion of the newly eligible population that will enroll in the program. Based upon an evaluation of program participation rates in the existing District of Columbia Medicaid program for children, we assume that 84 percent of newly eligible children who do not have private coverage will enroll in the program. Among newly eligible children with private coverage (includes employer and non-group coverage) as a dependent, 40 percent will drop their private coverage and enroll in Medicaid to take advantage of the fact that Medicaid does not require premium contributions. **See Attachment A**: **Derivation of Assumptions.** We assume that no one would shift from CHAMPUS to Medicaid because comprehensive coverage is available to these persons without a premium. The remainder would not enroll in the program.

- **Impact of Outreach Program:** The expansion in coverage will be associated with a vigorous outreach program designed to increase enrollment among eligible individuals. We assume that as long as this outreach program is in effect, about 20 percent of all persons who are eligible but not enrolled will sign up for the program. This assumption is based upon an analysis of the effects of other outreach programs.

- **Enrollment Lags:** Experience with prior Medicaid expansions indicates that it often takes several months for newly eligible persons to learn of their eligibility for a program. This results in a lag in the rate at which newly eligible persons will enroll in the program which tends to keep costs low in the initial months of the program. Proper estimation of these lags is necessary to accurately estimate program costs. We assume that about 25 percent of those who would enroll in the program do not enroll until the next year. This assumption is based upon observed lags in the rate at which newly eligible persons enrolled under prior expansions in Medicaid eligibility.

- **Cost per Enrollee**: The model estimates program costs by multiplying the average monthly number of persons enrolled in the program in each month by the average cost per member per month (PMPM) for each eligibility group. The PMPM estimates by eligibility group are based upon actual capitation payments for persons currently covered under the Medicaid managed care program for TANF and TANF-related groups, which was adjusted to include costs for mental health, long-term care and retrospective eligibility months for newly eligible

persons. Separate actuarial estimates are used for population groups that are not currently enrolled in the program.

1.1.2 What is the State's assessment of the reliability of the baseline estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Response: See response to question 1.1.2.

1.1.3 How much progress has been made in increasing the number of children with creditable health coverage (for example, changes in uninsured rates, Title XXI enrollment levels, estimates of children enrolled in Medicaid as a result of Title XXI outreach, anti-crowd-out efforts)? How many more children have creditable coverage following the implementation of Title XXI? (Section 2108(b)(1)(A))

Response: When the District of Columbia began it's Title XXI Medicaid expansion, it also expanded coverage for adults with dependent children and children age 19 through 21 under section 1931 of the Social Security Act. The combined effect of the Title XXI expansion and the section 1931 expansion is that we cover **all** children (through age 21) and their parents and all pregnant women up to 200 percent of the Federal poverty guidelines. The Districts Medicaid program for children and parents is named ***DC Healthy Families***. Enrollment in *DC Healthy Families* as of September 30, 1999:

	Number Actually Enrolled	**Number Expected to Enroll Based on Take-Up Rate Associated with Other Expansions**	**Percentage of Expected Enrollment**	**Universe of Eligible People**	**Percentage of Universe Enrolled**
Uninsured Expansion Kids (Targeted Low Income)	1,968	5,601	35%	8,957	21.9%
Expansion Kids with Insurance	470	No estimate available	N/A	No estimate available	N/A
Previously Medicaid Eligible but not Enrolled Kids	3,305*	4,023	82%	10,579	31%
Section 1931 Children (ages 19-21) Over Income for Medicaid but at or below 200% of Poverty	number not tracked separately from parent enrollment	No estimate available at this time	N/A	No estimate available at this time	N/A
Totals	Approximately 5,743 plus				

* This number derives from comparing actual enrollment to point in time projected enrollment based on a regression of two year of enrollment data. The data source for all numbers reported in table is the Automated Client Eligibility Determination System (ACEDS).

1.2.1 What are the data source(s) and methodology used to make this estimate?

Response: The data source for the expected take up rate and the universe of eligible individuals is described in section 1.1.1. The data source for actual enrollment is internal eligibility data.

1.2.2 What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Response: See response to question 1.1.2. The primary limitation of internal eligibility data is the instability of the data over time.

1.3 What progress has been made to achieve the State's strategic objectives and performance goals for its CHIP program(s)?

Please complete Table 1.3 to summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in the Title XXI State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List the State's strategic objectives for the CHIP program, as specified in the State Plan.

Column 2: List the performance goals for each strategic objective.

Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

For each performance goal specified in Table 1.3, please provide additional narrative discussing how actual performance to date compares against performance goals. Please be as specific as possible concerning your findings to date. If performance goals have not been met, indicate the barriers or constraints. The narrative also should discuss future performance measurement activities, including a projection of when additional data are likely to be available.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
The District did not have a strategic objective for this category.	Monitor number of children who were previously (pre-expansion) eligible but not enrolled in the Medicaid program on a monthly basis.	Data Sources: Internal eligibility data; Medicaid enrollment data Methodology: The District compared actual enrollment to a regression analysis (based on 2 years of enrollment data from F/Y 1996 through F/Y 1998) to determine approximate number of eligible but not enrolled children on a monthly basis. We projected to F/Y 2001 the trend in the enrollment of children in the program based upon historical data on monthly enrollment of children during F/Y 1996, F/Y 1997, and F/Y 1998 (pre-CHIP implementation). Numerator: Total number of uninsured children living in the District: **14,749 finish!** Denominator: Total number of children insured since October 1, 1998: 5,743 Progress Summary: The District of Columbia has reduced the number of uninsured children living in the District of Columbia by approximately 40%
OBJECTIVES RELATED TO CHIP ENROLLMENT		

Table 1.3		
The District will achieve at least 5 percent of its projected enrollment of CHIP eligible children within the first year of implementation of the eligibility expansion.	The District will collect data on the number of CHIP-eligible children enrolled in the program on a monthly basis.	Data Sources: Internal eligibility data; Medicaid enrollment data Methodology: Developed computer program to identify population Numerator: Number of Title XXI-eligible children expected to enroll; Number of Title XXI-eligible children in the universe. Denominator: Number of Title XXI-eligible children who have actually enrolled Progress Summary: The District has enrolled 35% of its expected enrollment and 21.9% percent of the universe of uninsured Title XXI children living in the District of Columbia.
OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		

Table 1.3

Within the first year of the eligibility expansion and its associated outreach strategy, the District will identify and enroll at least 35 percent of those children who are Medicaid-eligible but not enrolled.	The District will collect data on the number of Medicaid-eligible children enrolled in the program on a monthly basis.	Data Sources: Internal eligibility data; Medicaid enrollment data Methodology: Developed computer program to identify population Numerator: Number of Medicaid-eligible children expected to enroll; Number of Title Medicaid -eligible children in the universe. Denominator: Number of Medicaid-eligible children who have actually enrolled Progress Summary: The District has enrolled 82% of its expected enrollment and 31% percent of the universe of children living in the District of Columbia who were previously (e.g. pre-expansion) eligible for Medicaid but not enrolled.

OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)

Table 1.3		
Fifty percent of CHIP-enrolled children will have self-selected an HMO and a primary care provider within the first year of enrollment.	The District will monitor monthly data on CHIP enrollees and whether or not they were voluntary selections.	Data Sources: Enrollment broker monthly reports Methodology: Arithmetic calculation Numerator: The sum of all voluntary selection percentages for F/Y 1999 Denominator: Twelve months Progress Summary: The District's voluntary enrollment rate for F/Y 1999 was 78%. **Note:** The District does not separate CHIP-related data from aggregate HMO data. Therefore, the number reported represents the voluntary selection rate for all Medicaid-enrollees (of which the Title XXI population is a subset).
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		
The District did not have a strategic objective for this category.	The District monitors utilization of preventive services through HMO mandatory reporting mechanisms.	Data Sources: HMO Reports Methodology: Numerator: Denominator: Progress Summary: F/Y 1999 data not available at this time
OTHER OBJECTIVES		

Table 1.3		
Those newly enrolled in CHIP and Medicaid will express satisfaction with the new enrollment process.	The District will capture information related to consumer satisfaction with the eligibility determination process through its managed care enrollment broker.	Data Sources: Hotline data, reports from CBOs, advocates, providers, consumer focus group participants, in depth interviews with employers, other governmental entities and individuals. Methodology: Numerator: Denominator: Progress Summary: The District's eligibility determination time has been reduced from an average of 40 days to an average of 15 days since the beginning of DC Healthy Families. Most of the complaints that we are now hearing center on the recertification process. The District is now in the process of making systemic changes in the recertification process and developing an aggressive outreach campaign (in partnership with the HMOs) around recertification.
The District will develop and implement a process for determining the effectiveness of (a) the enrollment process, and (b) the City-wide outreach strategy.	The District will work through its managed care enrollment broker (and others) to elicit information from customers related to satisfaction with the eligibility determination process.	Data Sources: Hotline data, reports from CBOs, advocates, providers, consumer focus group participants, in depth interviews with employers, and other governmental entities and individuals. Methodology: Numerator: Denominator: Progress Summary: The two-page application has been well received throughout the community and recommendations for changes and improvements have been incorporated into additional printings. The application is located in over 500 community-based sites and applicants appear to appreciate not having to go to a "welfare office" to apply as most of the applicants access the application in community-based settings. Elimination of the face-to-face interview has also been well received by the community.

This section is designed to provide background information on CHIP program(s) funded through Title XXI.

2.1 How are Title XXI funds being used in your State?

2.1.1 List all programs in your State that are funded through Title XXI. (Check all that apply.)

__x__ Providing expanded eligibility under the State's Medicaid plan (Medicaid CHIP expansion)

Name of program:

Response: DC Healthy Families

Date enrollment Began:

Response: October 1, 1998.

___ Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (State-designed CHIP program)

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services):
_____

___ Other - Family Coverage

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services):
_____

___ Other - Employer-sponsored Insurance Coverage

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services):
_____

___ Other - Wraparound Benefit Package

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services):
_____

___ Other (specify) _____

Date enrollment began (i.e., when children first became eligible to receive services):
_____

2.1.2 **If State offers family coverage: Please** provide a brief narrative about requirements for Participation in this program and how this program is coordinated with other CHIP programs.

Response: When the District of Columbia began it's Title XXI Medicaid expansion, it also expanded coverage for adults with dependent children and children age 19 through 21 under section 1931 of the Social Security Act. The combined effect of the Title XXI expansion and the section 1931 expansion is that we cover **all** children (through age 21) and their parents and all pregnant women up to 200 percent of the Federal poverty guidelines. The District's Medicaid program for children and parents is named DC Healthy Families. The District has a single outreach effort designed to reach the entire eligible population (Title XXI, Section 1931, and those previously eligible for Medicaid but not enrolled). We have integrated these concepts into all functions of outreach (e.g. hotline, radio, TV, print material, etc.).

2.1.3 **If State has a buy-in program for employer-sponsored insurance:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

Response: N/A

2.2 2.2 What environmental factors in your State affect your CHIP program? (Section 2108(b)(1)(E))

2.2.1 How did pre-existing programs (including Medicaid) affect the design of your CHIP program(s)?

Response: Prior to beginning DC Health Families, there were two privately funded programs to insure children in the District, *KidsCare* and *KidsCare*. One of the programs, *KidsCare* stopped operating once DC Healthy Families was initiated. The other, *KaiserKids* increased its income eligibility criteria above 200% of poverty and redirected its outreach efforts to identify and enroll all children who are not eligible for Medicaid (pre-expansion and post expansion). This group includes: not qualified immigrants, immigrants barred for their first five years in the US, and children with family income between zero and 250 percent of poverty. Enrollment in KaiserKids **is now ____.**

When the District developed its expansion, a number of program changes were made to Medicaid in order to begin the process of making enrollment more consumer friendly. These include: (a) Development of a two-page, mail-in, immigrant friendly (with Spanish translation); (b) provision of a postage paid envelope with the application; (c) widespread distribution of the application in over 500 convenient locations throughout the community; (d) elimination of the face-to-face interview requirement; (e) development and monthly training of a bilingual hotline staff (languages include: English, Spanish, Vietnamese, Korean, and Chinese; (f) addition of TDD/TTY capacity to the hotline. **<u>See</u> Attachment B: DC Healthy Families Application; <u>See</u> Attachment C: List of DC Healthy Families Distribution Sites**.

2.2.2 Were any of the preexisting programs "State-only" and if so what has happened to that program?

___ One or more pre-existing programs were “State only” ! Describe current status of program(s): Is it still enrolling children? What is its target group? Was it folded into CHIP?

"affect the provision of accessible, affordable, quality health insurance and healthcare for children." (Section 2108(b)(1)(E))

Examples are listed below. Check all that apply and provide descriptive narrative if applicable. Please indicate source of information (e.g., news account, evaluation study) and, where available, provide quantitative measures about the effects on your CHIP program.

__x_ Changes to the Medicaid program

___ Presumptive eligibility for children
___ Coverage of Supplemental Security Income (SSI) children
___ Provision of continuous coverage (specify number of months ___)
__x_Elimination of assets tests
__x_Elimination of face-to-face eligibility interviews
__x_Easing of documentation requirements
__x_ Other: implementation of an intensive outreach campaign
__x_ Other: revision and shortening of Medicaid application
__x_ Other: election of section 1931 option to expand coverage to parents of eligible children, all pregnant women, and all children (including ages 19, 20, and 21).
__x__Adoption of more liberal methodology to measure unemployment for purposes of determining whether a child is deprived on the basis of the unemployment of parent.

__x_ Impact of welfare reform on Medicaid enrollment and changes to AFDC/TANF (specify)

Response: The District one of the few jurisdictions in the country where the number of Medicaid enrollees has gone up (as opposed to stagnated or declined) since the implementation of welfare reform. We attribute this, in part, to very liberal eligibility policies coupled with vigorous outreach.

___ Changes in the private insurance market that could affect affordability of or accessibility to private health insurance

___ Health insurance premium rate increases
___ Legal or regulatory changes related to insurance
___ Changes in insurance carrier participation (e.g., new carriers entering market or existing carriers exiting market)
___ Changes in employee cost-sharing for insurance
___ Availability of subsidies for adult coverage
___ Other (specify) _____

___ Changes in the delivery system

___ Changes in extent of managed care penetration (e.g., changes in HMO, IPA, PPO activity)
___ Changes in hospital marketplace (e.g., closure, conversion, merger)
___ Other (specify) _____

___ Development of new health care programs or services for targeted low-income children (specify) _____

___ Changes in the demographic or socioeconomic context

___ Changes in population characteristics, such as racial/ethnic mix or immigrant

1999.

___ Other (specify)_____
___ Other (specify) _____

delivery system, cost-sharing, outreach, coordination with other programs, and anti-crowd-out provisions.

3.1 Who is eligible?

3.1.1 Describe the standards used to determine eligibility of targeted low-income children for child health assistance under the plan. For each standard, describe the criteria used to apply the standard. If not applicable, enter "NA."

Table 3.1.1

	Medicaid CHIP Expansion Program	**State-designed CHIP Program**	**Other CHIP Program*** _____ _____
Geographic area served by the plan (Section 2108(b)(1)(B)(iv))	The District of Columbia; Wards 1through 8.		
Age	Birth through age 18		
Income (define countable income)	Countable Income: Gross income less dollar for dollar dependent care expenses		
Resources (including any standards relating to spend downs and disposition of resources)	N/A		
Residency requirements	Must reside in the District of Columbia		
Disability status	N/A		
Access to or coverage under other health coverage (Section 2108(b)(1)(B)(i))	N/A		

	of an alien verification number. The alien verification number is verified through the SAVE system. Immigrant applicants not required to produce photocopied documents. Must provide proof of social security number *only* for the person(s) for whom you are applying.		

**Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".*

Table 3.1.2

Redetermination	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Monthly			
Every six months			
Every twelve months	x		
Other (specify)			

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.1.3 Is eligibility guaranteed for a specified period of time regardless of income changes? (Section 2108(b)(1)(B)(v))

___ Yes ° Which program(s)?

For how long?

__x_ No

3.1.4 Does the CHIP program provide retroactive eligibility?

__x_ Yes ° Which program(s)?

Response: All Medicaid

How many months look-back?

Response: Three

___ No

3.1.5 Does the CHIP program have presumptive eligibility?

___ Yes ° Which program(s)?

Which populations?

Who determines?

__x_ No

Response: The District was very concerned that if it adopted presumptive eligibility, applicants would not follow up to secure permanent eligibility. We are closely monitoring the experiences of other jurisdictions that have adopted presumptive to determine whether the District should change its existing policy.

programs?

Response: No. Joint application *only* for Medicaid; not for other District programs.

___ No

3.1.7 Evaluate the strengths and weaknesses of your *eligibility determination* process in increasing creditable health coverage among targeted low-income children.

Response:

Strengths	Weaknesses
1. Two-page application	1. Proof of income required
2. Application available in English and Spanish	2. High turnover among eligibility workers
3. Immigrant friendly application (e.g. don't collect more information than is absolutely required to process. Undocumented parents can apply for their children without being identified.	3. Low compensation level of eligibility staff
4. Mail-in application	4. High and complex caseloads for eligibility staff
5. Business reply mail provided (no postage necessary)	
6. Less documentation required than pre-expansion	
7. No face-to face interview required	
8. Applications located in more than 500 sites throughout the community (e.g. grocery stores, drug stores, public libraries, motor vehicle department, childcare centers, public schools, etc.)	
9. Average length of time to process application decreased to approximately 15 days	

Response:

Strengths	Weaknesses
1. Mail-in re-certification process	1.Recertification form asks for more documentation than is required. **Note:** re-certification form in the process of being revised.
2. Re-certification form available in English and Spanish	2. Lack of consumer familiarity with the re-certification process and/or the process. **Note:** MAA is developing an outreach strategy to address this issue.
3. Individuals only re-certify once every 12 months	3. Individual is made to reapply for Medicaid if they miss their re-certification cut-off date.
4. Recertification notice mailed at 90 and 30 days	

3.2 What benefits do children receive and how is the delivery system structured? (Section 2108(b)(1)(B)(vi))

3.2.1 Benefits

Please complete Table 3.2.1 for each of your CHIP programs, showing which benefits are covered, the extent of cost sharing (if any), and benefit limits (if any).

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose “select” “table.” Once the table is highlighted, copy it by selecting “copy” in the Edit menu and then “paste” it under the first table.

Table 3.2.1 CHIP Program Type_____			
Benefit	Is Service Covered? (**T** = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Inpatient hospital services	x		
Emergency hospital services	x		
Outpatient hospital services	x		
Physician services	x		
Clinic services	x		
Prescription drugs	x		
Over-the-counter medications			
Outpatient laboratory and radiology services	x		
Prenatal care	x		
Family planning services	x		
Inpatient mental health services	x		
Outpatient mental health services	x		
Inpatient substance abuse treatment services	x		
Residential substance abuse treatment services			
Outpatient substance abuse treatment services			
Durable medical equipment	x		
Disposable medical supplies	x		
Preventive dental services	x		

Restorative dental services	x		
Hearing screening	x		
Hearing aids	x		
Vision screening	x		
Corrective lenses (including eyeglasses)	x		
Developmental assessment	x		
Immunizations	x		
Well-baby visits	x		
Well-child visits	x		
Physical therapy	x		
Speech therapy	x		
Occupational therapy	x		
Physical rehabilitation services	x		
Podiatric services	x		
Chiropractic services			
Medical transportation	x		
Home health services	x		
Nursing facility	x		
ICF/MR	x		
Hospice care	x		
Private duty nursing	x		

Personal care services	x		
Habilitative services	x		
Case management/Care coordination	x		
Non-emergency transportation	x		
Interpreter services	x		
Other (Specify) Residential Treatment	x (fee-for-service)		
Other (Specify) Special Program for Children with Special Health Care Needs.	x (SSI recipients)		
Other (Specify) All other services available under the Medicaid State Plan for the District of Columbia	x		

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose “select” “table.” Once the table is highlighted, copy it by selecting “copy” in the Edit menu and then “paste” it under the first table.

Please comment on the scope and range of health coverage provided, including the types of benefits provided and cost-sharing requirements. Please highlight the level of preventive services offered and services available to children with special health care needs. Also, describe any enabling services offered to CHIP enrollees. (Enabling services include non-emergency transportation, interpretation, individual needs assessment, home visits, community outreach, translation of written materials, and other services designed to facilitate access to care.)

Scope and Range of Health Coverage: All children and their parents receive services through a mandatory managed care program (with the exception of the following: (a) children receiving SSI; (b) women who are 26 weeks (or greater) pregnant (option to opt out of mandatory managed care; and (c) persons with HIV/AIDS (option to opt out of mandatory managed care. The District has contracts with seven HMOs. The contracts require the HMOs to provide the full Medicaid benefit package (including EPSDT), with the excpetion of long-term care and behavioral health. Long-term care and behavioral health are reimbursed on a fee-for-service basis.

The District has a voluntary PCCM program for children with special needs. Only children receiving SSI-cash (with limited exceptions) are eligible to enroll in the PCCM program. The program is voluntary and provides the full Medicaid benefit package as well as the following enhancement services: home modifications, respite care, and telephone installation.

Cost-sharing Requirements: None

Level of Preventive Services Offered: The District has a comprehensive EPSDT program that provides the following periodic service and any required treatment. Adults also have access to ongoing routine primary preventive care.

Enabling Services Offered: Emergency and non-emergency transportation, interpretation, outreach, individual needs assessment, case management, home visits, special classes (e.g.smoking cessation, nutrition, pregnancy), community outreach, translation of written materials.

Identify in Table 3.2.3 the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Check all that apply.

Table 3.2.3			
Type of delivery system	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
A. Comprehensive risk managed care organizations (MCOs)	YES		
Statewide?	__x_ Yes ___ No	___ Yes ___ No	___ Yes ___ No
Mandatory enrollment?	__x_ Yes ___ No (limited opt out provisions)	___ Yes ___ No	___ Yes ___ No
Number of MCOs	7		
B. Primary care case management (PCCM) program	N/A		
B. Non-comprehensive risk contractors for selected services such as mental health, dental, or vision (specify services that are carved out to managed care, if applicable)	HMOs subcontract for dental and vision.		
C. Indemnity/fee-for-service (specify services that are carved out to FFS, if applicable)	Services carved out of the managed care contracts: Behavioral Health services and long-term care services. Fee-for service reimbursement is available for these services		
E. Other (specify)			
F. Other (specify)			
G. Other (specify)			

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.3 How much does CHIP cost families?

3.3.1 Is cost sharing imposed on any of the families covered under the plan? (Cost sharing includes premiums, enrollment fees, deductibles, coinsurance/ copayments, or other out-of-pocket expenses paid by the family.)

__x_ No, skip to section 3.4

___ Yes, check all that apply in Table 3.3.1

Table 3.3.1

Type of cost-sharing	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*_____ _____
Premiums	N/A		
Enrollment fee	N/A		
Deductibles	N/A		
Coinsurance/copayments**	N/A		
Other (specify) _____			

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".
**See Table 3.2.1 for detailed information.

3.3.2 **If premiums are charged:** What is the level of premiums and how do they vary by program, income, family size, or other criteria? (Describe criteria and attach schedule.) How often are premiums collected? What do you do if families fail to pay the premium? Is there a waiting period (lock-out) before a family can re-enroll? Do you have any innovative approaches to premium collection?

3.3.3 **If premiums are charged:** Who may pay for the premium? Check all that apply. (Section 2108(b)(1)(B)(iii))

___ Employer
___ Family
___ Absent parent
___ Private donations/sponsorship
___ Other (specify) _____

3.3.4 **If enrollment fee is charged:** What is the amount of the enrollment fee and how does it vary by program, income, family size, or other criteria?

3.3.5 **If deductibles are charged: What** is the amount of deductibles (specify, including variations by program, health plan, type of service, and other criteria)?

3.3.6 How are families notified of their cost-sharing requirements under CHIP, including the 5 percent cap?

3.3.7 How is your CHIP program monitoring that annual aggregate cost-sharing does not exceed 5 percent of family income? Check all that apply below and include a narrative providing further details on the approach.

___ Shoebox method (families save records documenting cumulative level of cost sharing)
___ Health plan administration (health plans track cumulative level of cost sharing)
___ Audit and reconciliation (State performs audit of utilization and cost sharing)
___ Other (specify)_____

3.3.8 What percent of families hit the 5 percent cap since your CHIP program was implemented? (If more than one CHIP program with cost sharing, specify for each program.)

3.3.9 Has your State undertaken any assessment of the effects of premiums on participation or the effects of cost sharing on utilization, and if so, what have you found?

3.4 How do you reach and inform potential enrollees?

3.4.1 What client education and outreach approaches does your CHIP program use?

Please complete Table 3.4.1. Identify all of the client education and outreach approaches used by your CHIP program(s). Specify which approaches are used (**T**=yes) and then rate the effectiveness of each approach on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.1

Approach	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program* _____	
	T = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)
Billboards						
Brochures/flyers	x	5				
Direct mail by State/enrollment broker/administrative contractor	x	5				
Education sessions	x	5				
Home visits by State/enrollment broker/administrative contractor	x	5				
Hotline	x	5				
Incentives for education/outreach staff						
Incentives for enrollees						
Incentives for insurance agents						
Non-traditional hours for application intake	x	5				
Prime-time TV advertisements						
Public access cable TV	x	5				
Public transportation ads	x	5				
Radio/newspaper/TV advertisement and PSAs	x	5				

Developed by the National Academy for State Health Policy

Signs/posters	x	5				
State/broker initiated phone calls	x	5				
Integration of outreach strategy into other District programs (e.g. WIC, child care, foster care, etc.)	x	5				
Other (specify) Monthly newsletter to CBO, School, providers, and community members	x	5				
Activities targeted to employers	x	5				
Activities targeted to faith-based communities	x	5				
Establishment of an ongoing Immigrant Task Force	x	5				
Other (specify) Special Events: e.g. Community-based enrollment events, school-based contests, events at major sporting events.	x	5				

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

Note: All activities rated as "5" for effectiveness because of their synergistic and cumulative effect on the overall program. The District is not able to disaggregate the effectiveness of individual outreach strategies at this time.

Please complete Table 3.4.2. Identify all the settings used by your CHIP program(s) for client education and outreach. Specify which settings are used (**T**=yes) and then rate the effectiveness of each setting on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.2						
Setting	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program* _____	
	T = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)
Battered women shelters	x					
Community sponsored events	x	5				
Beneficiary's home						
Day care centers	x	5				
Faith communities	x	5				
Fast food restaurants	x	5				
Grocery stores	x	5				
Homeless shelters	x	5				
Job training centers	x	5				
Laundromats						
Libraries	x	5				
Local/community health centers	x	5				
Point of service/provider locations	x	5				
Public meetings/health fairs	x	5				
Public housing	x	5				
Refugee resettlement programs						

Developed by the National Academy for State Health Policy

Schools/adult education sites	x	5				
Senior centers	x	5				
Social service agency	x	5				
Workplace	x	5				
Other (specify) Other Businesses: tax preparation services, temporary employment agencies, taxi companies, barber shops, security companies, construction companies, hotels, recreation centers, convenience stores, and parking garages.	x	5				
Other (specify)						

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

Note: All activities rated as "5" for effectiveness because of their synergistic and cumulative effect on the overall program. The District is not able to disaggregate the effectiveness of individual outreach strategies at this time.

enrolled relative to the particular target population. Please be as specific and detailed as possible. Attach reports or other documentation where available.

Response: Methods used to determine effectiveness of outreach include:

1. Monitoring call volume on hotline (monthly)
2. Monitoring enrollment numbers (weekly)
3. Monitoring turn-out at special events
4. Monitoring number of impressions associated with radio and television
5. Monitoring number of responses to media appearances with "call-in" component
6. Monitor number of responses to print advertisements
7. Focus groups with consumers
8. Focus groups with employers
9. Meetings with community-based organizations
10. Discussions with providers

3.4.4 What communication approaches are being used to reach families of varying ethnic backgrounds?

Response:

1. Use of ethnic media
2. Use of ethnic outreach workers
3. Development and dissemination of culturally sensitive materials
4. Development and dissemination of language appropriate materials
5. Partnerships with community-based organizations
6. Establishment of an Immigrant Task Force with regularly scheduled meetings

3.4.5 Have any of the outreach activities been more successful in reaching certain populations? Which methods best reached which populations? How have you measured their effectiveness? Please present quantitative findings where available.

Response: Specific observations related to the District's outreach efforts include:

- There is a positive association between school-based outreach activities and number of applications received from school locations.
- It is beneficial to make applications available in both traditional and non-traditional locations. The District receives most of its approved applications from CVS drug stores, private clinics, HMOs, and public clinic.
- Outreach is very hard work and very expensive.
- It takes strong leadership and good coordination of outreach activities to reduce message chaos in the community.
- It would be very helpful if the *Covering Kids Initiative* would put more emphasis (in very practical ways) on coordination of efforts with state efforts.
- There needs to be more effort at the Federal level to change people's minds about the value of

access to care when they need or want it.

- It would be very helpful if the Federal government would fund more outreach evaluation projects and help states understand how to conduct good evaluation projects.

See Attachment D: Summary of Outreach Strategy; and Attachment E: Summary of Focus Group Results and Results of In Depth Interviews with Employers.

2108(b)(1)(D))

Describe procedures to coordinate among CHIP programs, other health care programs, and non-health care programs. Table 3.5 identifies possible areas of coordination between CHIP and other programs (such as Medicaid, MCH, WIC, School Lunch). Check all areas in which coordination takes place and specify the nature of coordination in narrative text, either on the table or in an attachment.

Table 3.5

Type of coordination	Medicaid*	Maternal and child health	Other (specify) Income Maintenance Administration (IMA)	Other (specify) Public Schools (including school lunch), Charter Schools, Parochial Schools, Mental Health Agency, Substance Abuse Agency, Child Care Agency, Foster Care Agency, WIC, Immigration and Naturalization Service, Faith Community, Business Community, Chamber of Commerce, Provider Groups, Head Start, and Sororities.
Administration			x	
Outreach		x	x	x
Eligibility determination			x	
Service delivery			x	
Procurement			x	
Contracting			x	
Data collection		x	x	
Quality assurance			x	
Other (specify) Consumer education		x	x	x
Other (specify) Application Assistance		x	x	x (selected groups)

*Note: This column is not applicable for States with a Medicaid CHIP expansion program only.

3.6.1 Describe anti-crowd-out policies implemented by your CHIP program. If there are differences across programs, please describe for each program separately. Check all that apply and describe.

x____Eligibility determination process:

___ Waiting period without health insurance (specify)
__x_ Information on current or previous health insurance gathered on application (specify)
___ Information verified with employer (specify)
___ Records match (specify)
___ Other (specify)
__x_ Other (specify)

___ Benefit package design:

___ Benefit limits (specify)
___ Cost-sharing (specify)
___ Other (specify)
___ Other (specify)

___ Other policies intended to avoid crowd out (e.g., insurance reform):

___ Other (specify)
___ Other (specify) _____

3.6.2 How do you monitor crowd-out? What have you found? Please attach any available reports or other documentation.

Response: The District monitors crowd-out by asking parents to indicate (on the DC Healthy Families Application) whether health insurance has been dropped in the last three months for any child for whom the parent is applying. The District has represented to the Federal government that it will monitor responses to this inquiry and develop a more proactive policy should the number of positive responses exceed 10 percent of all TitleXXI children. Fifteen percent of all individuals who applied checked the box stating that they had dropped health insurance within three months of applying for DC Healthy Families. The District is unable to report on the percentage of those who checked the box who were ultimately eligible for and enrolled in the Title XXI expansion although we suspect that not all individuals who stated that they dropped insurance actually were enrolled. The District is in the process of trying to identify a way to track not only how many dropped insurance but also how many of those who dropped insurance are ultimately enrolled.

This section is designed to assess the effectiveness of your CHIP program(s), including enrollment, disenrollment, expenditures, access to care, and quality of care.

4.1 Who enrolled in your CHIP program?

4.1.1 What are the characteristics of children enrolled in your CHIP program? (Section 2108(b)(1)(B)(i))

Please complete Table 4.1.1 for each of your CHIP programs, based on data from your HCFA quarterly enrollment reports. Summarize the number of children enrolled and their characteristics. Also, discuss average length of enrollment (number of months) and how this varies by characteristics of children and families, as well as across programs.

States are also encouraged to provide additional tables on enrollment by other characteristics, including gender, race, ethnicity, parental employment status, parental marital status, urban/rural location, and immigrant status. Use the same format as Table 4.1.1, if possible.

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose "select" "table." Once the table is highlighted, copy it by selecting "copy" in the Edit menu and then "paste" it under the first table.

Table 4.1.1 CHIP Program Type Medicaid Expansion

Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children		2180				
Age						
Under 1		40				
1-5		128				
6-12		741				
13-18		1271				
Countable Income Level*						
At or below 150% FPL						
Above 150% FPL						

Under 1						
At or below 150% FPL						
Above 150% FPL						
1-5						
At or below 150% FPL						
Above 150% FPL						
6-12						
At or below 150% FPL						
Above 150% FPL						
13-18						
At or below 150% FPL						
Above 150% FPL						
Type of plan						
Fee-for-service		635				
Managed care		1790				
PCCM		N/A				

*Countable Income Level is as defined by the states for those that impose premiums at defined levels other than 150% FPL. See the HCFA Quarterly Report instructions for further details.

SOURCE: HCFA Quarterly Enrollment Reports, Forms HCFA-21E, HCFA-64.21E, HCFA-64EC, HCFA Statistical Information Management System, October 1998

Response: **See** Attachment F: Quarterly Report submitted to HCFA for all quarters in F/Y 1999 (Title XXI eligible only). The District did not break out countable income above and below 150 percent of poverty.

4.1.2 How many CHIP enrollees had access to or coverage by health insurance prior to enrollment in CHIP? Please indicate the source of these data (e.g., application form, survey). (Section 2108(b)(1)(B)(i))

Response: Data not available. Children who are insured, but income eligible are enrolled in Medicaid under section 1931.

4.1.3 What is the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children? (Section 2108(b)(1)(C))

Response: See response to question 2.2.1.

4.2 Who disenrolled from your CHIP program and why?

Response: Information not available. The District is in the process of identifying appropriate system changes to capture the information.

4.2.1 How many children disenrolled from your CHIP program(s)? Please discuss disenrollment rates presented in Table 4.1.1. Was disenrollment higher or lower than expected? How do CHIP disenrollment rates compare to traditional Medicaid disenrollment rates?

Response: Information not available. The District is in the process of identifying appropriate system changes to capture the information.

4.2.2 How many children did not re-enroll at renewal? How many of the children who did not re-enroll got other coverage when they left CHIP?

Response: Information not available. The District is in the process of identifying appropriate system changes to capture the information.

4.2.3 What were the reasons for discontinuation of coverage under CHIP? (Please specify data source, methodologies, and reporting period.)

Response: The District of Columbia does not track reasons for discontinuation of coverage in its Medicaid Program at this time. We are in the process of exploring ways in which we might go about tracking this information.

Table 4.2.3

Reason for discontinuation of coverage	Medicaid CHIP Expansion Program		State-designed CHIP Program		Other CHIP Program* _____	
	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total
Total						
Access to commercial insurance						
Eligible for Medicaid						
Income too high						
Aged out of program						
Moved/died						
Nonpayment of premium						
Incomplete documentation						
Did not reply/unable to contact						
Other (specify)						
Other (specify)						
Don't know						

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

Response:

1. Monthly direct mail piece to persons who lost eligibility
2. Improving the recertification form
3. Outreach through community-based organizations, HMOs, and others
4. Developing flyers and brochures on the need to recertify
5. Incorporating information about recertification into educational trainings
6. Working with HMOs to develop a direct mail piece for mailings to their members

4.3 How much did you spend on your CHIP program? **FINISH**

4.3.1 What were the total expenditures for your CHIP program in federal fiscal year (FFY) 1998 and 1999?

FFY 1998 _____N/A_____

FFY 1999 _____$1,632,981_____

Please complete Table 4.3.1 for each of your CHIP programs and summarize expenditures by category (total computable expenditures and federal share). What proportion was spent on purchasing private health insurance premiums versus purchasing direct services?

Table 4.3.1 CHIP Program Type ____Medicaid Expansion_____				
Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total expenditures		$1,632,981.00		
Premiums for private health insurance (net of cost-sharing offsets)*		Capitation Payment: $1,002,410.28		
Fee-for-service expenditures (subtotal)		Total Fee for Service Expenditures: $630,570.91		
Inpatient hospital services				
Inpatient mental health facility services				
Nursing care services				
Physician and surgical services				

services				
Outpatient mental health facility services				
Prescribed drugs				
Dental services				
Vision services				
Other practitioners' services				
Clinic services				
Therapy and rehabilitation services				
Laboratory and radiological services				
Durable and disposable medical equipment				
Family planning				
Abortions				
Screening services				
Home health				
Home and community-based services				
Hospice				
Medical transportation				
Case management				
Other services				

See Attachment G: Breakdown of Title XXI Expenditures (not including U3 expenditures)

summarize expenditures by category.

What types of activities were funded under the 10 percent cap?

Response: To Be Determined

What role did the 10 percent cap have in program design?

Response: None

Table 4.3.2						
Type of expenditure	Medicaid Chip Expansion Program		State-designed CHIP Program		Other CHIP Program* _____	
	FY 1998	FY 1999	FY 1998	FY 1999	FY 1998	FY 1999
Total computable share						
Outreach		$700,000				
Administration						
Other_____						
Federal share						
Outreach						
Administration						
Other __ _____						

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.3.3 What were the non-Federal sources of funds spent on your CHIP program (Section 2108(b)(1)(B)(vii))

Response:

_x__ State appropriations
___ County/local funds
___ Employer contributions
___ Foundation grants
___ Private donations (such as United Way, sponsorship)
___ Other (specify) _____

4.4 How are you assuring CHIP enrollees have access to care?

4.4.1 What processes are being used to monitor and evaluate access to care received by CHIP enrollees? Please specify each delivery system used (from question 3.2.3) if approaches vary by the delivery system within each program. For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in a Primary Care Case Management program, specify 'PCCM.'

Table 4.4.1

Approaches to monitoring access	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Appointment audits	x (temporarily on hold)		
PCP/enrollee ratios	x		
Time/distance standards	x		
Urgent/routine care access standards	x		
Network capacity reviews (rural providers, safety net providers, specialty mix)	x		
Complaint/grievance/ disenrollment reviews	x		
Case file reviews	x		
Beneficiary surveys	x		
Utilization analysis (emergency room use, preventive care use)	x		
Other (specify) _____			
Other (specify) _____			
Other (specify) _____			

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

your State has no contracts with health plans, skip to section 4.4.3.

Table 4.4.2			
Type of utilization data	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Requiring submission of raw encounter data by health plans	___ Yes __x_ No	___ Yes ___ No	___ Yes ___ No
Requiring submission of aggregate HEDIS data by health plans	_x_ Yes ___ No	___ Yes ___ No	___ Yes ___ No
Other (specify)_____	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.4.3 What information (if any) is currently available on access to care by CHIP enrollees in your State? Please summarize the results.

Response:

4.4.4 What plans does your CHIP program have for future monitoring/evaluation of access to care by CHIP enrollees? When will data be available?

Response:

4.5 How are you measuring the quality of care received by CHIP enrollees?

Response:

particularly with respect to well-baby care, well-child care, and immunizations? Please specify the approaches used to monitor quality within each delivery system (from question 3.2.3). For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in primary care case management, specify 'PCCM.'

Response: The District of Columbia does not collect separate information on Title XXI enrollees in its Medicaid Program from the Health Plans. All children (Title XIX and XXI are enrolled in mandatory managed care and the health plans report out aggregated data to us on all of these children). The District of Columbia takes a comprehensive approach to ensuring high quality service delivery through its seven contracted managed care plans. They include:

1. Conducting Readiness Reviews: Before health plans may begin to enroll members, they have to demonstrate that they have fully executed contracts with an adequate number of accessible providers, plans for emergency provider coverage, and adequate tracking systems to handle member and provider inquiries, complaints, appeals, and grievances.

2. Monitoring Individual complaints: All managed care enrollees can call the Managed Care HELPLINE to make an inquiry or file a complaint, and all complaints are investigated and resolved within 30 days. The District has installed a full service complaint tracking system to support this activity.

3. Monitoring Performance Measures: Each HMO agrees to submit reports on a series of measures such as emergency room visits, low birth rates, and EPSDT participation rates so that performance can be tracked.

4. Conducting External Quality Reviews: The District of Columbia has a contract with the Delmarva Foundation (the Federally designated peer review organization for this region of the Country) to conduct an annual evaluation of health plan performance.

5. Conducting Provider and Enrollee Surveys: Each HMO is required to conduct two enrollee surveys a year. In addition, the Medical Assistance Administration is performing surveys of HMO providers and enrollees with the assistance of an outside contractor. This year, recipient surveys will focus on reasons for health plan disenrollment.

6. Making Provider Calls:

Table 4.5.1

Approaches to monitoring quality	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program
Focused studies (specify)	x		
Client satisfaction surveys	x		
Complaint/grievance/ disenrollment reviews	x		

Plan site visits	x		
Case file reviews	x		
Independent peer review	x		
HEDIS performance measurement	x		
Other performance measurement (specify)	x		
Other (specify) _____			
Other (specify) _____			
Other (specify) _____			

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.5.2 What information (if any) is currently available on quality of care received by CHIP enrollees in your State? Please summarize the results.

Response:

4.5.3 What plans does your CHIP program have for future monitoring/evaluation of quality of care received by CHIP enrollees? When will data be available?

Response: The District of Columbia does not collect separate information on Title XXI enrollees in its Medicaid Program from the Health Plans. All children (Title XIX and XXI are enrolled in mandatory managed care and the health plans report out aggregated data to us on all of these children). We will continue to monitor the quality of care of children enrolled in Title XXI in the same manner that we monitor the quality of care that all children receive through the District's managed care program.

4.6 Please attach any reports or other documents addressing access, quality, utilization, costs, satisfaction, or other aspects of your CHIP program's performance. Please list attachments here.

SECTION 5. REFLECTIONS

This section is designed to identify lessons learned by the State during the early implementation of its CHIP program as well as to discuss ways in which the State plans to improve its CHIP program in the future. The State evaluation should conclude with recommendations of how the Title XXI program could be improved.

5.1 What worked and what didn't work when designing and implementing your CHIP program? What lessons have you learned? What are your "best practices"? Where possible, describe what evaluation efforts have been completed, are underway, or planned to analyze what worked and what didn't work. Be as specific and detailed as possible. (Answer all that apply. Enter 'NA' for not applicable.)

8.1.1 Eligibility Determination/Redetermination and Enrollment

Response: The District's expansion program is a little over a year old and we are now experiencing the

redetermination. We are working hard to develop and implement an outreach/education strategy on this issue.

5.1.2 Outreach

Response: See response to section 3.4.5.

5.1.3 Benefit Structure:

Response: N/A

5.1.4 Cost-Sharing (such as premiums, copayments, compliance with 5% cap):

Response: N/A

5.1.5 Delivery System

Response: The District had no difficulty enrolling Title XXI children into the existing managed care program.

5.1.6 Coordination with Other Programs (especially private insurance and crowd-out):

Response: N/A

5.1.7 Evaluation and Monitoring (including data reporting)

Response:

5.1.8 Other (specify)

Response:

5.2 What plans does your State have for "improving the availability of health insurance and health care for children"? (Section 2108(b)(1)(F))

Response: Recently the Mayor's Health Care System Development Commission made recommendations to expand coverage and increase access to health care for District Residents. Specifically, the Commission set forth three goals: (a) to improve the health care system and services for vulnerable populations; (b) to increase insurance coverage and decrease the number of uninsured District residents; and (c) to improve the capacity of the department of Health to monitor and assess the quality and effectiveness of the health system. A set of specific recommendations were made in order to realize the goals. **See** Attachment H: Proposed Council Resolution

5.2 What recommendations does your State have for improving the Title XXI program? (Section 2108(b)(1)(G))

Response: